

# NEWS LETTER FROM KIYOSE

The Research Institute of Tuberculosis, JATA  
3-1-24 Matsuyama, Kiyose-shi, Tokyo 204-8533, Japan

No.37, December 2021



- Letter from the Director ..... 1
- In memory of Dr. Shimao.....2-3
- Ensuring Continuity of TB Services  
Amidst the COVID-19 Pandemic..... 4
- Kiyose International Club 30<sup>th</sup> Anniversary Celebration.....4-5

- Lessons from Japanese management  
and technology toward ending TB.....5-6
- Removal of Cambodia from the WHO list of  
30 high TB burden countries..... 6
- International cooperation activities during the pandemic..... 7-8
- The Double burden of COVID-19 and the COUP in Myanmar....8

## -Letter from the Director- What's new at RIT amid the COVID-19 pandemic

### Seiya Kato Director

Two years have passed since the appearance of COVID-19 on the globe. The status of the pandemic is changing due to variant strains, vaccination coverage, the strategy by the governments, the behavior of people etc.



#### The Current situation of COVID-19 in Japan

Japan has experienced five waves of the epidemic as of October 2021. The fifth wave seems to relate to the spread of the Delta strain of which infectivity is high. The Tokyo Olympic and Paralympic games were held amidst the fifth wave, when the Declaration of Emergency for COVID-19 was issued. There was concern that these big sporting events might negatively affect people's preventive behavior and induce an unacceptable situation. Careful isolation of athletes and game officials from the general population (named the "bubble") was taken to prevent cross transmission. The number of the infected among the general population increased until August 19<sup>th</sup>, while the effective reproduction number gradually dropped from the opening of the Olympic games, suggesting that preventive behavior of people and increasing vaccination coverage had been changing the situation. Fortunately, both events were completed without any serious incident. It could be a model for the following Olympic and Paralympic Games. After reaching a peak, the number of the infected declined sharply, probably owing to decrease of human movement, behavioral change of people, increase of vaccination coverage etc., however, the exact reasons for the rapid

decline aren't clear so far. So, concern about an occurrence of a sixth wave persists.

#### Influence on TB control in Japan

According to the 2020 annual report, notification of TB in Japan was 10.1/ 100,000 with annual decline rate of 12.1%, which was very high compared to 7% in the previous two years. Preventive precautions, i.e. to avoid the Three Cs (Closed spaces, Crowded places, Close-contact setting) may have contributed to a decrease in TB infection, however, such rapid decline of incidence should not happen in Japan, because most of the aged TB patients had got infected a long time ago. So the main reasons for the decline in 2020 seems to be deteriorated case finding due to decrease of annual screening, weakened contact examinations, restraint in consultation to physician etc. Decrease of migrants from high TB burden countries was also one of the reasons.

#### Impact on the activities of RIT

As a response to the COVID-19 pandemic, RIT introduced remote work and staggered working hours. Research activities are affected because of difficulty in on-site data collection, conducting questionnaire surveys, transportation of materials, etc. Trainings, technical supports, and meetings even inside the institute are held online. Online meeting has shortcomings in holding Q & A sessions, however, utilizing the chat function can be a solution for this issue. Webinars have the advantage that many participants can be included at a low cost. As far as international activities are concerned, opportunities of communication have increased markedly using online meetings and webinars. "Good morning, good afternoon and good evening" is a common greeting in global online meetings. It is a bit of a bother for us that most of the global meetings are held late at night in Japan.

#### Fight against COVID-19 and TB

We need to collaborate our response to the COVID-19 pandemic, which affects all aspects of the world. As a technical agency for TB, RIT will continue working toward attainment of the End TB Strategy alleviating negative impacts of the COVID-19 pandemic. We can positively acknowledge that application of ITC technology to TB control has progressed amidst the COVID-19 pandemic.

## **We miss Shimao-sensei (1924-2021)**

### **Nobukatsu Ishikawa Director Emeritus of the RIT/JATA**

Dr. Tadao Shimao (Shimao-sensei), Director Emeritus of RIT passed away on 28 March 2021 at the age of 96. He was a giant who devoted his whole life to TB. Shimao-sensei was an epidemiologist, teacher, and clinician until 92 years of age. His works have huge implications to recent challenges in TB care and prevention under the End TB strategy. His lecture on global TB and historical overview and its control in Japan were greatly appreciated. I remember 2 issues he addressed; 1) the development of TB programme though vertical in early days had contributed to the development of UHC in Japan, 2) spending huge amount of military budget by cutting welfare and health budget during the rapid modernization in Japan during 1870s-1945 caused a high TB mortality and morbidity for several decades. He shouldered TB physically himself as well. He got TB soon after joining JATA and experienced the patient's life for nearly 3 years. He had pneumothorax therapies and later underwent thoracoplasty and lobectomy under local anesthesia, so painful in his days confronted always with the fear of dying. However, he overcame it with his strong spirit and trained body by Judo. He told us that the experience of being a TB patient had great impact on his professional life. He served the Union and WHO both as a member of the boards. He extended his work to HIV/AIDS prevention and antismoking. We would like to succeed his ways of life with strong spirit, together with his students worldwide.

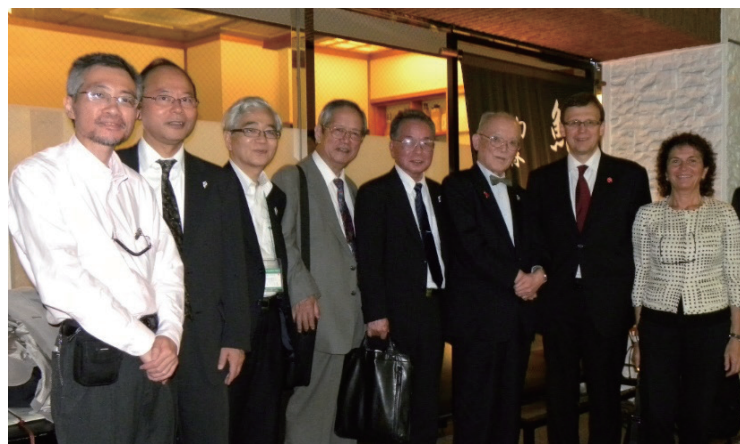


## **In memory of Dr. Shimao-sensei**

### **Mario C. Raviglione, University of Milan, Italy and former WHO GTB Director (2003-2017)**

I joined the small Tuberculosis Unit at the World Health Organization Headquarters in August 1991 – 30 years ago - as a Junior Professional Officer (JPO). Just a few days after my arrival in Geneva, a CARG Task Force met (CARG was the Coordination, Advisory and Review Group of the WHO Tuberculosis Unit at the time). That was my very first international meeting on tuberculosis (TB). I was sitting in the back of the room, but I remember some of the participants in that Task Force meeting and I recall the presence of a Japanese expert whose behaviour and attitude spontaneously demanded respect. It was three months later, in November 1991, when I was more aware of the international TB scene, that I met Shimao-sensei in person at the CARG meeting that he chaired. He impressed me with the quiet tone of his voice and the profound wisdom transpiring from his speaking. Subsequently, I met Shimao-sensei in many meetings and events over the years. My last encounter with him was in Tokyo on 3 June 2011, 10 years ago, when in the occasion of the annual JATA congress, I was invited with my wife Angela for a dinner by JATA and RIT colleagues, the “cream” of the fight against TB in Japan. I sat close to Dr. Shimao and for the whole excellent dinner, we discussed about our common goal of ending TB, but also of the Japanese culture, that fascinated us, of Kyoto and Tokyo, and of the past memories of WHO meetings and people.

Dr. Shimao was a giant in the global fight against TB. His work, teaching, knowledge and passion will be remembered for ever. I feel privileged to have met him and honoured of having had the pleasure to spend quality time with him. Rest in peace, Shimao-sensei.



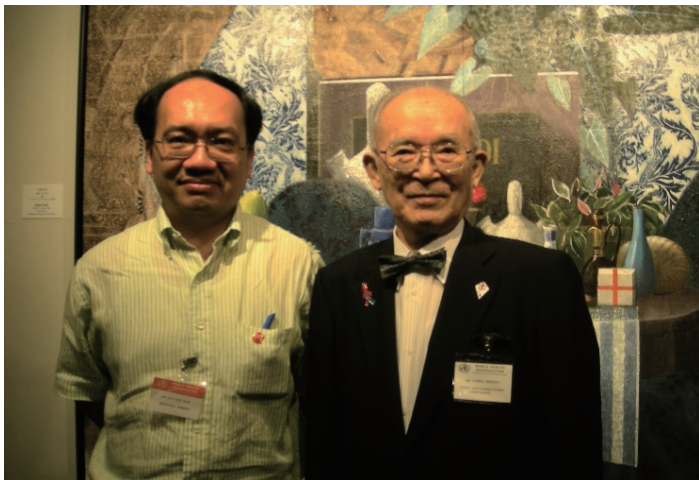
## In memory of Dr. Tadao Shimao

**Kai Man KAM,  
The Chinese University of Hong Kong**

Dr. Tadao Shimao was one of the few pioneers to recognize the power of randomization and importance to studying a clinical /epidemiological situation. He was the first to bravely apply this analytical method and use of chest X-ray examination to a TB programme in an Asian setting. Through his keen observations and endurance, he was instrumental in planning, execution and analysis of the first national TB prevalence survey in Japan in 1953. (*Kekkaku: [Tuberculosis]* 84(11):713-20). This then set the stage for other Asian countries/ areas to follow.

With emergence of drug resistant TB worldwide, Dr. Shimao was keen to point out that Japan's role should be to develop simple techniques that allow multidrug-resistant strains to be detected and new drugs to follow in the footsteps of Otsuka Pharmaceutical's new anti-tuberculosis drug.

When I met with Dr. Shimao in one of the JATA/RIT TB Laboratory Training course, I learned how he had personally suffered from TB disease and its consequences. Through understanding his vast knowledge, experiences and humility (*Kekkaku [Tuberculosis]* 75(7):483-91), he had been a constant source of inspiration for many of his followers and students, including myself. His lifetime, immense contributions to TB research and studies would last in the memory of generations.



Dr. Kai Man KAM (left), Dr. Shimao (right) July 2008, Tokyo

## Photo Gallery of Dr. Shimao



Dr. Shimao (center) at JICA Lab training course



Dr. Shimao (left) in the Great Wall of China



Dr. Shimao (Right) and 1<sup>st</sup> international training participants in the field visit (1963, Japan)

## Ensuring Continuity of TB Services Amidst the COVID-19 Pandemic

**Anna Marie Celina G. Garfin, Department of Health, Republic of the Philippines**

The first local transmission of COVID-19 in the Philippines was reported on March 7, 2020, and on March 16, 2020, a community quarantine was started in Metro Manila and was subsequently implemented nationwide. With the community quarantine, everybody was instructed to stay at home except for the essential workers and medical front-liners. Public transportation was not allowed, nor were large gatherings. These restrictions hampered the daily and routine activities of everyone, as well as the implementation of the National TB Control Programme (NTP).

Just before the imposition of the community quarantine, the Programme was able to introduce the use of the rapid molecular test as the primary diagnostic tool for TB as well as the use of standard short all oral regimen for drug resistant TB. These policy changes helped mitigate the effect of COVID-19 in the provision of TB services. Health workers were also instructed to provide a one-month supply of anti-TB drugs to patients on treatment. There was also implementation of community-based care treatment, and the use of digital adherence tools.

To monitor the effect of the COVID-19 pandemic on TB services, weekly meetings with partners was done that served as a venue to provide updates on what was happening in the field, to discuss the issues and concerns, and to plan and implement actions.

Rapid assessment of the provision of TB services showed that there were disruptions in the cascade of TB care. Active casefinding activities were put on hold since gathering of people was prohibited, health workers prioritized response to COVID-19, movement of the people were restricted due to the community lock-downs, and very few people sought consultation due to fear of contracting COVID-19. TB Testing was also limited due to inadequate personal protective equipment, and some machines were used to improve access to COVID-19 testing. For treatment, there were delays in the delivery of drugs due to limited availability of transportation. For prevention, contact investigation was not done due to restrictions in the movement of the people, and because of stigma.

A study done by the University of California San Francisco showed an immediate decline in the daily notification of TB cases, with numbers markedly declining during the first 10 days after the announcement of quarantine. The effect was also shown through

Stop TB modeling showing a continued low level of TB detection in the next 3 months following the quarantine.

These findings warranted modified delivery of TB services together with the efforts to address the COVID-19 pandemic. This prompted the Programme to come up with the NTP Adaptive Plan (NAP) to ensure continuation of TB services and to provide guidance on doable measures during the pandemic. The key guidance of the NAP is to continue active case finding activities despite the pandemic, observance of infection prevention and control measures, flexibility in management of cases, and health systems adjustment. Activities will also be done to complement the response to the COVID-19 pandemic.

A year after the pandemic, data showed that there was a 37% decrease in TB notification, 8% decrease in the treatment success rate (TSR) among the new and relapse TB cases, and 9% increase in the TSR of drug resistant TB cases (most likely due to the introduction of short all oral regimen and community-based treatment).

The COVID-19 pandemic showed that innovations are needed to cope with the pandemic. Integration of services is also important due to limited resources.

Acknowledgement to key partners of the NTP: TB Innovations, TB Platforms and STAR projects of the United States Agency for International Development, World Health Organization, and ACCESS TB project of The Global Fund.

## Kiyose International Club 30<sup>th</sup> Anniversary Celebration

Kiyose International Club (KIC) celebrates its 30<sup>th</sup> anniversary this year. KIC was founded in 1991 and the initial activity was to exchange friendship with international training participants of the Research Institute of Tuberculosis (RIT). The number of foreign nationals who lived in Kiyose city has increased and there are over 1,300 people (as of 1 January 2021) from more than 50 different countries living here. Nowadays, they can meet and exchange their experiences through KIC activities.

KIC provides RIT participants with the opportunity to experience Japanese culture. Let's take a look back at some of our memories.



Photo: Learning about Japanese culture (through games) in Japanese Language Class by KIC. Each participant wears a newspaper helmet on their head, which is called “Kabuto”. They are trying to put a coin into a “ochoko” (a small sake cup) which is in the sink full of water.



Photo: Dancing “Bon-Odori”(Japanese Dance) at KIC international exchange party; participants are dancing while wearing “Happi” (traditional Japanese coats worn during festivals).

We hope RIT participants can have an enjoyable time through the activities offered by KIC.

## Lessons from Japanese management and technology toward ending TB: Let’s do Kenshin to detect and treat more TB patients to have fewer TB patients in the future

**Ikushi Onozaki, Executive Advisor, International Programmes, JATA**

Warm Greetings from Kiyose. I regret that we missed the last two RIT alumni meetings on the occasions of the UNION conference. The international courses at RIT also became online ones and were shorter. Though those online courses were held very successfully with active contributions of your country colleagues, participants couldn’t see rural Japan and meet people directly.

Many RIT/JICA international course alumni still remember a field visit to observe mobile annual health check programmes in rural communities, though different classes in different years visited different prefectures or municipalities. It included TB screening by X-ray van using mass-miniature X-ray (MMR) in the earlier days and direct digital X-ray recently. We call it “Kenshin”, active health-check programme. The local ladies’ volunteer group actively mobilized residents to join and work with public health nurses from municipality offices and medical teams from public health agencies.

One mobile X-ray unit covers 300 or more people who participated in the programme each day. When TB was the national disease in Japan in mid-20<sup>th</sup> century, annual Kenshin in the community and workplace was highly effective at detecting TB patients earlier or those who missed diagnosis in the past for any reason. When TB prevalence was high, such active case detection with X-ray screening followed by smear and culture examinations could detect more TB patients than those detected by passive case detection at health care facilities. It might be one of the vital components that led to significant reduction of TB case notification and incidence around 10% annually for two decades, from more than 500 per 100,000 in 1960 to less than 60 in 1980.

However, such mass screening programmes were discouraged by WHO in 1974, when they advised countries to stop mass-screening programmes with MMR. Therefore, systematic case detection with X-ray screening hadn’t been introduced at community level in most TB high burden countries.

However, in the last decades, we began to realize that there was a higher TB burden than we thought in many countries through national TB prevalence surveys. Prevalence/annual notification ratio often exceeded two: In communities where you detected and treated 100 patients a year, you actually had more than 200 bacteriologically positive TB patients staying in community without any TB treatment. Can we stop TB transmission in such a situation?

Thus, WHO revised TB incidence estimate upward in the mid-2010s when more countries completed prevalence surveys. Estimated incidence of TB, once down to 8 million globally, became more than 10 million, but not because of the increase of TB. It was because of under estimation in the old days with technologies with limited sensitivity to detect TB. Although we celebrated achievement of the 70% case detection target in many countries in 2005, current WHO estimates suggested that real case detection rate at that time was less than 50%. We haven’t been detecting and treating TB patients enough.

In March 2021, WHO released a new version of guidelines of systematic TB screening that promotes more use of CXR screening potentially with Computer Aided Diagnostic technology (CAD) in combination with WHO recommended rapid molecular diagnostics.

The COVID-19 pandemic has prevented many TB patients from proper diagnosis and treatment. TB prevalence in community may become much higher than previously due to delay or missing the opportunity to have appropriate care. ACD, or systematic case detection, will become more important in the post-Covid era. RIT recently hosted two web programmes to accelerate systematic TB case detection with CXR in collaboration with WHO Western Pacific Region, UNION and partners.

Japanese experiences and technologies are contributing to better access to quality diagnosis. Development and improvement of digital and portable radiography systems bring quality imaging to the community. Our popular motorbikes and 4WD cars are widely used to make those equipment and field staff reach the community. The key issue you should take into account when you begin systematic case detection or active case finding is coverage. Since you and your staff have capacity, you may be able to develop a successful project to deliver quality care to the community. However, it is essential to spread your good model widely to expand the service, to create momentum of national decline of TB burden. Here you may need new technologies and lessons from experiences in Japan. For example, CAD may help as we don't have an adequate number of radiologists to screen all X-ray images; successful expansion of ACD in Japan was sustained by outsourcing to private sector including prefectural branches of JATA; daily coverage of 300 or more is feasible with good community participation and good maintenance of X-ray units. We should be bold enough to cover all TB high burden communities to detect and treat at least 90% of patients. It is important to develop a plan according to your local context. Even within your country, needs are different from place by place and time to time. Those technologies may be useful not only for active case detection but also for primary care level hospitals. Once we got significant reduction of TB by bold interventions, absolute expenditure and proportion of spending on TB among national health budget have been significantly declining in Japan. Spending enough now is saving for the future.

We are happy to share our experiences in Japan through virtual and face to face classes in Kiyose and technical assistance by various channels. Please don't hesitate to contact us to seek opportunities to work together for the sake of hidden and undetected TB patients toward ending TB.

## Removal of Cambodia from the WHO list of 30 high TB burden countries

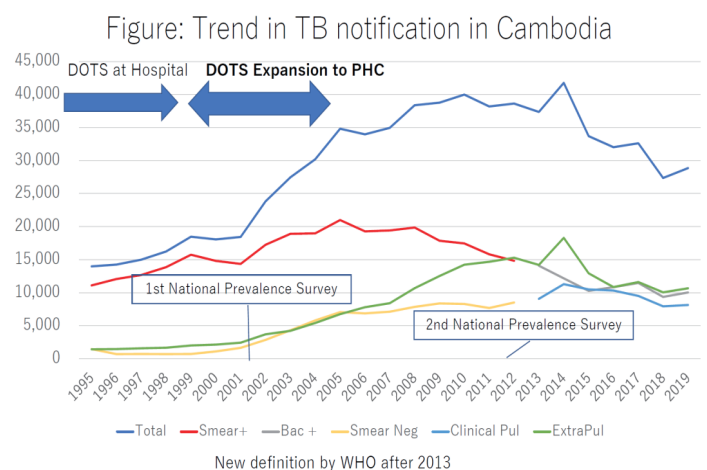
**Kosuke Okada, Board of Directors, Head of International Programmes, JATA**

Cambodia, where TB had been widespread due to the devastation under the Pol Pot regime and the consequent civil war, was removed from the WHO list of 30 high TB burden countries in 2021. Despite that Cambodia was one of the highest TB burden countries in the world, with an estimated incidence of 579 per 100,000 population in 2000. TB services were limited with only 155/100,000 patients'

enrollment, based on smear microscopy for diagnosis and two-month hospitalized DOT at hospitals. In 1999, DOTS expansion to the primary care level started, technically supported by a JICA Project; presumptive TB patients didn't need to go to a district hospital because of the newly established sputum transportation system from health centers to the TB laboratory. To promote an evidence-based strategy, a national TB prevalence survey, an HIV sero-prevalence survey among TB patients, and a drug resistance survey were planned to understand the existing situations.

Recognizing the importance of TB among Cambodia's health problems, the Government designated Dr. Mao Tan Eang as director of the National Center for TB and Leprosy Control in 2001. He demonstrated outstanding leadership in improving the TB situation in Cambodia. In the first national prevalence survey in 2001-2002, the prevalence of culture positive TB exceeded 1% in the population over 15 years old. Following the results of significantly higher prevalence of TB in remote villages, Dr. Eang hastened to expand DOTS to village-level health centers; health centers with DOTS services increased from 160 to more than 1000 in four years. At the health center where DOTS was launched, community DOTS was also promoted in collaboration with NGOs. Consequently, the patient enrollment increased by 80% to 283/100,000 in 2010. The experience of prevalence surveys using chest x-ray contributed to the promotion of active case finding in high-risk populations as well as to the development of Global Guidelines for TB Screening.

Cambodia's case notification rates showed a declining trend that peaked as 283/100,000 in 2010 and decreased to 178/100,000 in 2019. The repeat prevalence survey in 2011 revealed that the current strategy in TB high burden countries can halve the prevalence of bacteriological-positive pulmonary TB in ten years, from 579/100,000 in 2000 to 287/100,000 in 2019, indicating that the reduction in patient notification in Cambodia reflected the reduction in tuberculosis incidence. As a result, Cambodia has become one of the few countries which have been removed from the WHO list due to a clear reduction in tuberculosis.



## International cooperation Activities during the pandemic: Not only challenges but opportunities

### Norio Yamada Head, Centre for International Cooperation and Global TB Information, RIT/JATA

I would like to report briefly how RIT/JATA carried out international cooperation activities, and what activities were carried out, for the past one year during the COVID-19 pandemic.

JICA online training course: The JICA training courses have been carried out at RIT since 1963. This year, the 59th year, we conducted training online for the first time.

The first online TB control course (JICA Knowledge Co-Creation Programme “Ending TB in the Era of Universal Health Coverage toward Sustainable Development Goals”) was carried out on 1 -12 February 2021. The duration of the course was 2 weeks, much shorter than the regular course of 8 weeks because it was thought that it was difficult for NTP staff to join the course for a longer period even if it were online. Because of the short course and because the impact of COVID-19 on the TB programme had already been recognized, we focused on problems caused by the pandemic and possible actions for coping with them. At the time of writing this article, we are conducting the course.

The TB laboratory course “JICA Knowledge Co-Creation Programme in Ending TB and AMR in the Era of UHC” was also conducted online. TB laboratory courses have emphasized both management aspects and a hands-on component (lab practice). Because an online course is not suitable for the hands-on component, the course focused on management aspects. We had 9 participants from Afghanistan, Bhutan, Democratic Republic of the Congo, Nepal, Philippines and Thailand. At the end of the course, the participants developed an action plan and we had presentations and discussions of action plans. Due to the large time difference between participants, both training courses consist of on-demand lectures which can be watched at a convenient time for participants and online sessions for discussion.

Due to the pandemic, we decided to conduct the JICA course online again in Japanese fiscal year 2021. We focused on accelerated TB detection because it is more important than ever since COVID-19 has affected case detection very seriously and new WHO guidelines of TB screening was published. We had 8 participants from 7 countries who joined the course.

Western Pacific Region TB Innovation Series 3/2021: In collaboration with rGLC (regional green light committee) Western Pacific Region, RIT hosted the webinar “Finding missing TB cases: Choosing algorithms and tools”. In this webinar, we had

very informative presentations about WHO guidelines on systematic screening, screening algorithms, ultra-portable digital X-ray, computer-aided detection (CAD), procurement process and panel discussions, and an overall Q&A session. From RIT/JATA, Dr. Ikushi Onozaki made a presentation entitled “The Role of X-ray in TB: evaluation” and Dr. Okada facilitated the Q&A session. The brochure and recording of this webinar can be watched currently on the RIT website (<https://jata.or.jp/english/>).

Online workshop, “Systematic screening for TB at clinical settings: Don’t miss the TB patients at hand!” in the 52th Union World Conference on Lung Health in October 2021: The workshop was coordinated by Dr. Kosuke Okada (RIT/JATA) and chaired by Dr. Bintari Dweihardiani of the Zero TB Yogyakarta Project, Center for Tropical Medicine, Faculty of Medicine, Public Health, and Nursing, Gadjah Mada University, Indonesia, and Dr. Ikushi Onozaki, RIT/JATA. This workshop can currently be watched on our YouTube site (<https://www.youtube.com/watch?v=6grPSGsHJKw>).

Because you can watch it on YouTube, I would like to highlight only two presentations. From RIT, Dr. Seiya Kato, Director, provided a presentation entitled, “The Role of mass screening with CXR in Japan”. Chest X-ray screening contributed greatly to case detection. In 1960 just before health insurance was introduced, 28% of the cases were detected through screening. At that time the medical cost before diagnosis was a barrier to consultation with a doctor. TB screening provided opportunities for TB diagnosis for those with financial barriers to consulting doctors. Among the patients detected through screening, only 21% of them were aware of tuberculosis. For implementation, collaboration among national government, local governments, the private sector, and civil society was important. The Government ensured funding. TB control law stipulated the responsibility for implementing screening to health of organizations, schools, workplaces, welfare facilities, and municipalities. The local anti-tuberculosis women’s association encouraged community members to take part in TB screening.

From Cambodia, Dr. Tieng Sivanna and Dr. Huout Chyanyuda, National Center for TB and Leprosy Control, Cambodia presented “How Cambodia graduated from the list of 30 HBCs – Possible Factors contributing to the graduation”. This presentation shared the experience of achieving a sharp decline of incidence and notification after DOTS expansion by decentralization of DOTS and expansion of X-ray service and also shows that epidemiologic studies such as repeated prevalence surveys, which were carried out with support from JICA, WHO, RIT and other partners, contributed to promoting evidence-based strategies of the TB programme, as Dr Okada mentioned in another article of this newsletter. RIT/JATA also supported The Union Student Late-Breaker session. I co-chaired the session with Dr. Caries Tudor of The Union.

Technical assistance for planning of prevalence surveys in Thailand and Cambodia: RIT/JATA provided technical assistance to the last prevalence surveys in Thailand and the 1<sup>st</sup> and 2<sup>nd</sup> prevalence surveys in Cambodia. Cambodia and Thailand have a plan for the next TB prevalence survey. We started technical assistance through online meetings. In April, the Cambodia NTP organized an online partner meeting. Dr. Onozaki made a presentation about the previous prevalence survey in Cambodia and the prevalence survey carried out in other countries after the last survey to provide a basis for discussion on designing the next survey.

The pandemic has prevented us from meeting and working together in person. However, we have recognized that for some activities, online implementation can provide opportunities for more people than onsite implementation that we can't join because it is not possible to travel there. It is sensible to utilize both online and onsite activities. In the last issue of the newsletter, I wrote "COVID-19 and the TB programme: challenges and opportunities" which indicated that the activities of coping with the problem caused by the COVID-19 pandemic can lead to strengthen the TB programme while the pandemic has had a serious negative impact on the TB programme. While we hope to see friends and colleagues in person in the future, we have gained more ways of working together for End TB.

## The Double burden of COVID-19 and the COUP in Myanmar

The spread of COVID-19 started in Myanmar in March 2020. The country now has a total of 449,845 laboratory confirmed cases according to the Johns Hopkins COVID-19 map<sup>1</sup>. During the first and second waves, the Ministry of Health was able to respond efficiently and effectively. On 1 February, the military staged the coup and thousands of health care workers joined the civil disobedience movement to show their will against the dictatorship. Without conducting appropriate preventive measures, the regime forced schools to reopen amid the surge in COVID-19 cases. With the collapsed health system, and mismanagement, a third wave of COVID-19 hit the country hard. Starting from July 2021, the positive cases were skyrocketing with new cases breaking their own record daily. The cemeteries have been overwhelmed and the incinerators have been exceeding their daily capacity. CDM medical staff opened charity clinics with the community's support and some help with tele-consultation. But the junta continued issuing warrants and arresting CDM medical staff and medical volunteers. Health care is in chaos. On social media, most of the newsfeeds in July were filled with the dire need of oxygen and condolences on the loss of friends, family members, relatives, and

colleagues. A colleague of mine and I decided to raise funds to fill the oxygen requirement as much as we could. We started a mini oxygen concentrators loan project with funding raised through our social networks. A total of 12 10L oxygen concentrators were procured and they filled the oxygen needs of some patients in Yangon. When the caseload in Yangon started to decline, we relocated 8 machines to the remote areas where there was an increase in COVID-19 cases. Apart from that, I did teleconsultation for the COVID-19 patients. Unfortunately, I lost my uncle under my care due to COVID-19. The family had to struggle daily to meet the oxygen requirements and to try to get him admitted to the hospital, but my uncle didn't have the chance to get admitted to the hospital. Private hospitals are very expensive for the ordinary people. The sad thing is that he didn't get the proper end of life care. He had to suffer till his last breath and I had to experience that. There were a lot of similar cases in the community. Myanmar's people suffered a lot from COVID -19 and experienced unnecessary loss of life due to the COUP. (KM)

1 COVID-19 Map - Johns Hopkins Coronavirus Resource Center. (2021). Retrieved 20 September 2021, from <https://coronavirus.jhu.edu/map.html>

### Message from the Publisher:

We are now basically not sending hard copies by postal mail, but this "NEWS LETTER FROM KIYOSE" No.37 can also be reviewed at the following links:

English: <https://www.jata.or.jp/english/>

Japanese: <https://jata.or.jp/english/centre/html#newsletter>

Please send us your messages and updated contact information to: [newsletter@jata.or.jp](mailto:newsletter@jata.or.jp) or you could fax to: +81-42-492-8258

### Staff Transitions:

#### Newly joined RIT/JATA:

Dr. Khay Mar Aung

#### Left RIT/JATA:

Ms. Mari Kaneoka

Mr. Yoshihiro Imoto

You are welcome to send us your news and voices!

### NEWS LETTER FROM KIYOSE

**Publisher: S. Kato, Director**

**Editor: N.Yamada, K.Toyama, A.Nakao**

**The Research Institute of Tuberculosis (RIT)**

**Japan Anti-Tuberculosis Association (JATA)**

**3-1-24 Matsuyama, Kiyose-shi, Tokyo 204-8533, Japan**

**Phone:+81-42-493-5711 Fax:+81-42-492-4600**

**E-mail:newsletter@jata.or.jp**

**Website:https://www.jata.or.jp/english/**